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Related Clinical Coverage Policies

Refer to http://www.ncdhhs.gov/dma/mp/ for the related coverage policies listed below:

1E-6, *Pregnancy Medical Home (PMH)*
1E-4, *Fetal Surveillance*
1K-7, *Prior Approval for Imaging Procedures*
1L-1, *Anesthesia*
1M-3, *Health and Behavioral Intervention*
1M-5, *Home Visit for Postnatal Assessment and Follow-up Care*
1M-6, *Maternal Care Skilled Nurse Home Visit*
4A, *Dental Services*
8A, *Enhanced Mental Health and Substance Abuse Services*
1-I, *Dietary Evaluation and Counseling*
8B, *Inpatient Behavioral Health Services*
8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*
8L, *Mental Health/Substance AbuseTargeted Case Management*
12B, *Human Immunodeficiency Virus (HIV) Case Management*

1.0 Description of the Procedure, Product, or Service

Obstetrics is a branch of medical science that deals with maternity care, including antepartum care, labor and delivery, and postpartum care. Standards of care are published by the American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control (CDC), and the American College of Nurse Midwifery (ACNM) for the perinatal care of the mother.

Information on services provided in clinical coverage policy 1E-6, *Pregnancy Medical Home (PMH)* can be found on DMA's Website at http://www.ncdhhs.gov/dma/mp/.

1.1 Definitions

None Apply.

2.0 Eligible Beneficiaries

2.1 General Provisions

Medicaid beneficiaries may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.1 Regular Medicaid

Female beneficiaries in this eligibility category are eligible for antepartum, labor and delivery, and postpartum care.

2.1.2 Medicaid for Pregnant Women

Female beneficiaries of all ages with Medicaid for Pregnant Women (MPW) coverage are eligible for pregnancy-related antepartum, labor and delivery, and postpartum care as well as services for conditions that—in the judgment of their physician—may complicate pregnancy. Conditions that may complicate the pregnancy can be further defined as any condition that may be problematic or

detrimental to the well-being or health of the mother or the unborn fetus such as undiagnosed syncope, excessive nausea and vomiting, anemia, and dental abscesses (This list is not all-inclusive.). The eligibility period for MPW coverage ends on the last day of the month in which the 60th postpartum day occurs [42 CFR 447.53(b)(2)].

Refer to **Subsection 5.1** for information on referring MPW beneficiaries for non-obstetrical pregnancy-related treatment services.

2.1.3 Undocumented Aliens

Undocumented aliens are eligible only for emergency medical services[42 CFR 440.255(c)], which includes labor and vaginal or cesarean section (C-section) delivery as defined in 10A NCAC 21B .0302. Services are authorized only for actual dates that the emergency services were provided.

Note: The local department of social services in the county where the alien resides determines eligibility coverage dates when the emergency service is for labor and delivery (vaginal or C-section delivery). The Division of Medical Assistance (DMA) determines eligibility coverage for all other emergency services, including miscarriages and other pregnancy terminations.

2.1.4 Presumptive Eligibility

Section 1920(b) of the Social Security Act allows for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility status is being determined. Ambulatory Antepartum Care can be defined as the level of prenatal care typically provided in primary-level facilities that covers assessment of the normal progress of pregnancy. This includes physical examinations; routine laboratory assessments; appropriate screening tests including basic fetal ultrasound (s), AFP tests, glucola tests, and etc.; and prenatal information and education.

The pregnant woman shall apply for Medicaid no later than the last day of the month following the month she is determined presumptively eligible. If the pregnant woman fails to apply for Medicaid within this time period, she is eligible only through the last calendar day of the month following the month she is determined presumptively eligible. If the pregnant woman applies for Medicaid within this time frame, she remains presumptively eligible for Medicaid until the local department of social services makes a determination on her application.

In the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination, the presumptive eligibility period ends.

Note: Presumptive eligibility is limited to one presumptive eligibility period per pregnancy.

2.1.5 Retroactive Eligibility

Retroactive eligibility applies to this policy.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Antepartum Care

The initial and subsequent antepartum visits include the history, physical examination; and recording of weight, blood pressure, fetal heart tones, and laboratory tests including urinalysis and urine hemoglobin analysis performed at the time of the visit.

3.2.1 Antepartum Visits

The frequency and number of antepartum visits are determined by the needs of the beneficiary. A beneficiary with an uncomplicated pregnancy is generally seen on the following schedule:

a. Every 4 weeks for the first 28 weeks of gestation
b. Every 2 to 3 weeks until the 36th week of gestation
c. Weekly from the 36th week of gestation until delivery

Note: the beneficiary may be seen more frequently if her condition warrants.

3.2.2 Individual Antepartum Services

Individual antepartum services (use of Evaluation and Management codes) are covered if

a. a pregnancy is high risk and requires more than the normal amount of services for a routine pregnancy; or
b. antepartum care is initiated less than three months prior to delivery; or

c. the beneficiary is seen by a provider between one (1) and three (3) office visits as specified in **Attachment B: Billing for Obstetrical Services**.

Clinical coverage policy 1E-6, *Pregnancy Medical Home*, on DMA's Website at http://www.ncdhhs.gov/dma/mp/, provides information on the definition of high-risk pregnancy and risk factors.

Note: Hospital-Based Entities as defined by 42 CFR 413.65 shall bill individual antepartum services without the restrictions of **Subsection 3.2.2**.

Note: Local Health Departments (LHDs) who provide high-risk antepartum care will bill appropriate Evaluation and Management (E/M) codes for individual antepartum services as specified in **Subsection 3.2.2**.

3.2.3 Counseling

Refer to DMA's Clinical Coverage Policy 1M-3, *Health and Behavioral Intervention* (on DMA's Website at http://www.ncdhhs.gov/dma/mp/), for information on counseling services for behavioral intervention.

Refer to clinical coverage policy 8A, *Enhanced Mental Health and Substance Abuse Services*, 8B, *Inpatient Behavioral Health Services*, 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*, and 8L, *Mental Health/Substance Abuse Targeted Case Management*, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/, for information on behavioral health treatment.

Refer to clinical coverage policy 1-I, *Dietary Evaluation and Counseling* (on DMA's Web site at http://www.ncdhhs.gov/dma/mp/), for information on dietary counseling services.

3.2.4 Fetal Surveillance Testing

Medicaid covers medically necessary fetal surveillance testing. Refer to clinical coverage policies 1E-4, *Fetal Surveillance* and 1K-7, *Prior Approval for Imaging Procedures*, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/, for additional information.

3.2.5 Case Management

Case management services for pregnant women is covered through DMA's clinical coverage policy 1E-6, *Pregnancy Medical Home* for beneficiaries assessed as high-risk and clinical coverage policy 12B, *Human Immunodeficiency Virus (HIV) Case Management* policy. Refer to DMA's Website at http://www.ncdhhs.gov/dma/mp/ for additional information on case management services for PMH and HIV case management services.

3.3 Package Services

3.3.1 Antepartum Package Services

Antepartum package services are covered when the attending provider rendering the antepartum care does not perform the delivery. The attending provider or

group provider shall have seen the beneficiary for at least three consecutive months during her pregnancy**.**

Note: Individual antepartum visits are not covered in conjunction with antepartum package services. Refer to **Attachment A, Claims-Related Information,** for billing instructions.

3.3.2 Global Obstetrics Services

Antepartum care, labor and delivery, and postpartum care are covered as an all-inclusive service (CPT codes 59400 or 59510) when

a. antepartum care was initiated at least three months prior to the delivery and
b. the same provider who renders the antepartum care performs the delivery and postpartum care.

3.3.3 Postpartum Package Services

Postpartum package services are covered when the attending provider

a. has not provided any antepartum care, but performs the delivery and provides postpartum care (CPT codes 59410 or 59515); or
b. has not provided any antepartum care and did not perform the delivery, but performs all postpartum care (CPT code 59430); or
c. bills individual visits for antepartum care due to a high-risk condition (CPT codes 59410, 59430, or 59515).

3.4 Consultations

Inpatient and outpatient consultations are covered when medical records substantiate that the services are medically necessary.

Refer to clinical coverage policies 1M-6, *Maternal Care Skilled Nurse Home Visit* and 1M-5, *Home Visit for Postnatal Assessment and Follow-up Care*, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/, for additional information on these services. These services require a physician's referral.

3.5 Labor and Delivery

Vaginal delivery includes episiotomy, the delivery of the placenta, external cephalic version, and special services associated with delivery.

Note: When there are extenuating circumstances and a certified or licensed provider other than the attending provider or provider group performs the episiotomy, it may be covered as a separate procedure. When a provider other than the attending physician or physician group performs the delivery of the placenta, it may be covered as a separate procedure. Refer to **Section 5.0, Requirements for and Limitations on Coverage,** for additional information.

3.5.1 Anesthesia

Anesthesia services are covered separately. Refer to clinical coverage policy 1L-1, *Anesthesia*, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/, for information on anesthesia and obstetrics.

3.5.2 Complications Related to Delivery

Medicaid covers complications related to delivery when the diagnosis substantiates medical necessity.

3.5.3 Multiple Births

If the beneficiary delivers multiple babies, vaginally or by C-section, the appropriate modifiers and diagnosis codes shall be used for reimbursement. Refer to **Attachment A, Claims-Related Information.**

3.5.4 Stand-by Services

Anesthesia stand-by is defined as the anesthesiologist's or certified registered nurse anesthetist's (CRNA's) standing by until it is determined whether services are required to administer and/or monitor anesthesia.

Physician stand-by service is covered for anesthesia services. This service is available only for physician stand-by services at high-risk deliveries. Only stand-by services related to the mother can be billed. The service shall be requested by a physician, and a diagnosis substantiating the high risk shall be documented on the claim (A list of these diagnosis codes can be found in **Attachment A**, letter B "Diagnosis Codes"). Medical records documenting the high-risk delivery and the need for stand-by services are not required with the claim submission, but shall be available for DMA or its agents upon request.

Medicaid covers physician stand-by services for

a. Care provided to the mother during a high-risk delivery [refer to **Attachment A,** letter B (Diagnosis Codes)]; and
b. Attendance at delivery and initial stabilization of the newborn during a high-risk delivery [refer to **Attachment A,** letter C (Procedure Codes)].

3.6 Postpartum Care

Postpartum services encompass management of the mother after delivery and during the postnatal period. Components of this service may include postpartum examination and contraceptive counseling. Medicaid covers medically approved family planning methods such as Nuva Ring, Birth Control Pills, Depo-Provera, IUD's (Paraguard and Mirena), Ortho Evra, sterilizations including the Essure procedure, Implanon, emergency contraceptive counseling, contraceptive management procedures, and pharmaceuticals to prevent conception. This includes services for beneficiaries with MPW coverage during their postpartum eligibility period.

Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs.

Note: For continued services after the 60th day, refer MPW beneficiaries to the Department of Social Services for continuing eligibility determination.

3.6.1 Vaccinations

Medicaid covers vaccinations for measles, mumps, rubella (MMR)/rubella component for women who do not have evidence of immunity and other vaccinations as recommended by the Advisory Committee on Immunization

Practices (ACIP) and the Center for Disease Control (CDC). The vaccine is provided upon completion or termination of pregnancy and before discharge from the health-care facility.

The ACIP recommendations for varicella vaccination indicate that women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy, according to ACIP protocol, and before discharge from the health care facility. The second dose should be administered between 4 and 8 weeks after the first dose. Medicaid covers the varicella vaccine series when provided according to this schedule and if the beneficiary is eligible for Medicaid on the day the service is provided.

Rhogam is a medication that is given to prevent Rhesus (Rh) hemolytic disease of the newborn (HDN). HDN is a serious, often fatal disease caused by incompatibility between an Rh-negative mother and her Rh-positive fetus. Medicaid covers rebatable NDCs for Rho D immune globulin in the postpartum period. This includes beneficiaries with MPW coverage.

Medicaid covers inpatient and outpatient immunizations for Tetanus toxoid, Diptheria toxoid, and Acellular Pertussis (Tdap) for beneficiaries during the postpartum period. ACIP recommends that adults who have or who anticipate having close contact with an infant less than 12 months of age and who previously have not received Tdap should receive a single dose of Tdap to protect against pertussis and reduce the likelihood of transmission. Tdap can be administered regardless of interval since the last tetanus- or diphtheria-toxoid containing vaccine. After receipt of Tdap, persons should continue to receive Td for routine booster immunization against tetanus and diphtheria, according to immunization guidelines.

Refer to **Attachment A, Claims-Related Information,** for a list of covered procedures.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Emergency Services for Undocumented Aliens

The following antepartum and postpartum services are not covered for undocumented aliens for emergency services.

ICD-10-CM Code(s)		
0U570ZZ	0UL70DZ	0UL74DZ
0U573ZZ	0UL70ZZ	0UL74ZZ
0U574ZZ	0UL73CZ	0UL77DZ
0U577ZZ	0UL73DZ	0UL77ZZ
0U578ZZ	0UL73ZZ	0UL78DZ
0UL70CZ	0UL74CZ	0UL78ZZ

CPT Code	Description
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure)(List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59425	Antepartum care only; 4–6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only; including postpartum care

The following CPT procedure codes will be considered for coverage only in an emergency situation such as an ectopic pregnancy:

CPT Code	Description
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

Sterilization procedures are not included in the definition of emergency services and therefore are not covered for undocumented aliens. Refer to **Subsection 2.1.3, Undocumented Aliens.**

4.3 Stand-by Services

a. Medicaid does not cover stand-by services for pre-anesthesia evaluations.
b. Medicaid does not cover stand-by services for the mother and for the newborn when provided by the same provider.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval for MPW Beneficiaries

Prior approval is required for MPW beneficiaries when the physician determines that any of the services listed below are needed for the treatment of a medical illness, injury, or trauma that may complicate the pregnancy.

a. Podiatry;
b. Chiropractic;
c. Optometric and optical services;
d. Home health;
e. Personal care services;
f. Hospice;
g. Private duty nursing;
h. Home infusion therapy; or
i. Durable medical equipment.

Refer to the specific clinical coverage policies on DMA's Web site at http://www.ncdhhs.gov/dma/mp/ for specific requirements for prior approval for MPW beneficiaries.

Clinical coverage policy 4A, *Dental Services*, on DMA's website at http://www.ncdhhs.gov/dma/mp/, describes dental services available to beneficiaries with MPW. These services require the same prior approval as dental services to any other beneficiary with full Medicaid coverage and are covered through the day of delivery.

5.2 Limitations

The following limitations apply to obstetric care services.

a. Individual delivery procedures (vaginal delivery and delivery of placenta) are not covered more than once in a 225-day period.

   Note: When there is more than one pregnancy within 225 days and both pregnancies result in separate deliveries on different dates of service within 225 days, the service is covered.

b. Antepartum care package services are covered once during the beneficiary's pregnancy. In special circumstances (for example when the beneficiary moves), up to 3 different providers can bill for 59425 (Antepartum care; 4–6 visits). This does not apply to different providers in the same group.

c. Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs. Refer to **Subsection 3.6, Postpartum Care.**

d. Stand-by services related to the mother for a high-risk delivery are limited to two hours per day.

e. Performance of an episiotomy or delivery of a placenta by a provider other than the attending physician is covered only through the adjustment process.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Update Information

Original Effective Date: October 1, 1985

Revision Information:

Date	Section Revised	Change
8/1/09	Throughout	Updated language to DMA's current standard.
8/1/09	Section 7.0	Deleted previous paragraphs on Federal & State Requirements and Records Retention and substituted Compliance.
8/1/09	Subsection 3.5.4, Att. A	Added diagnosis codes allowable for billing anesthesia stand-by for high-risk deliveries related to the mother.
8/1/09	Attachment A	Clarified billing practices for multiple births.
8/1/09	Attachment B	Added E/M codes 99217 through 99239 to the "Evaluation and Management Services" section; they cannot be reimbursed separately if billed with CPT codes 59400, 59410, 59425, 59426, 59430, 59510, or 59515.
9/1/11	1.0, added 2.1.5, 3.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, 3.3.3, 3.4, 3.6, 3.6.1, Attachment A-Sections C and E.	Added PMH reference in Section 1.0. Added Subsection 2.1.5. Revised wording in Subsections 3.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, and 3.3.3. Added information about policy 1M-6. Added family planning information in Subsection 3.6 and added rhogam and Tdap information in Subsection 3.6.1. Revised the information for FQHC and RHC billing for codes T1015, 59409, 59410, 59430, 59514, and 59515 in Attachment A, Section C. Clarified billing for multiple births in Attachment A, Section E.
9/1/11	Section 1.0	Added reference to PMH.
9/1/11	Subsection 2.1.2 and 2.1.4	Clarified conditions that complicate the pregnancy. Added definition of Ambulatory Antepartum Care and clarified Presumptive Eligibility coverage.
9/1/11	Subsection 2.1.5	Added this section to the policy.

Date	Section Revised	Change
9/1/11	Subsections 3.2, 3.2.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, and 3.3.3	Referenced PMH and added information about Hospital-Based Entities in Subsection 3.2.2. Referenced LHDs in Subsection 3.2.2. and added letter "c". Revised wording to remove Maternity Care Coordination section and to add information about Health and Behavioral Intervention, Enhanced Mental Health and Substance Abuse, Inpatient Behavioral Health Services, and Mental Health/Substance Abuse Targeted Case Management to Subsection 3.2.3. Added reference to the Prior Approval for Imaging Procedures policy to Subsection 3.2.4. Revised information for case management and removed information about the Baby Love Program. Removed statement " …with the intention of performing the delivery." from Subsection 3.3.1. Added CPT codes to match the service in Subsections 3.3.2 and 3.3.3. Added letter "c" in 3.3.3.
9/1/11	Subsection 3.4	Added reference to the Maternal Care Skilled Nurse Home Visit and Postnatal Assessment and Follow-up Care policies. Deleted Prior Approval note.
9/1/11	Subsection 3.5.4	Removed statement regarding anesthesia stand-by services related to the mother.
9/1/11	Subsection 3.6	Added family planning information.
9/1/11	Subsection 3.6.1	Added rhogam information and Tdap information.
9/1/11	Attachment A-Section B	Added numbers and changed title of the table.
9/1/11	Attachment A-Section C	Added information about PMH, Indian Health Services and PMH procedure codes. Added information regarding LHD billing. Moved information regarding Birthing Center billing from CPT code 59410 to CPT code 59409.
9/1/11	Attachment A-Section E	Added new table to depict billing for multiple gestations.
9/1/11	Attachment A-Section E	Clarified billing for multiple births. Removed the word "Consecutive" and added the word "Additional" in the table title.
9/1/11	Attachment B	Added Billing information for 1-3 visits using E/M codes.
9/1/11	Throughout	Updated language to DMA's current standard
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Diagnosis Codes that Substantiate High-Risk Deliveries for Maternal Stand-by Service

ICD-10-CM Code(s)			
0U570ZZ	O14.03	O41.1032	O47.03
0U573ZZ	O14.12	O41.1033	O71.02
0U574ZZ	O14.13	O41.1034	O71.03
0U577ZZ	O14.22	O41.1035	O71.1
0U578ZZ	O14.23	O41.1039	O74.1
0UL70CZ	O14.92	O41.1211	O74.2
0UL70DZ	O14.93	O41.1212	O74.3
0UL70ZZ	O15.02	O41.1213	O74.8
0UL73CZ	O15.03	O41.1214	O75.0
0UL73DZ	O15.9	O41.1215	O75.1
0UL73ZZ	O16.1	O41.1219	O75.2
0UL74CZ	O16.2	O41.1221	O75.3
0UL74DZ	O16.3	O41.1222	O87.1
0UL74ZZ	O22.31	O41.1223	O88.011
0UL77DZ	O22.32	O41.1224	O88.012
0UL77ZZ	O22.33	O41.1225	O88.013
0UL78DZ	O24.011	O41.1229	O88.02
0UL78ZZ	O24.012	O41.1231	O88.03
D65	O24.013	O41.1232	O88.111
D66	O24.111	O41.1233	O88.112
D67	O24.112	O41.1234	O88.113
D68.0	O24.113	O41.1235	O88.211
D68.1	O24.311	O41.1239	O88.212
D68.2	O26.611	O41.1411	O88.213
D68.311	O26.612	O41.1412	O88.22
D68.312	O26.613	O41.1413	O88.23
D68.318	O26.831	O41.1414	O88.311
D68.4	O26.832	O41.1415	O88.312

D68.8	O26.833	O41.1419	O88.313
I09.9	O30.001	O41.1421	O88.32
I50.1	O30.002	O41.1422	O88.33
I50.20	O30.003	O41.1423	O88.811
I50.22	O30.011	O41.1424	O88.812
I50.23	O30.012	O41.1425	O88.813
I50.30	O30.013	O41.1429	O88.82
I50.31	O30.031	O41.1431	O88.83
I50.32	O30.032	O41.1432	O99.111
I50.33	O30.033	O41.1433	O99.112
I50.40	O30.041	O41.1434	O99.113
I50.41	O30.042	O41.1435	O99.281
I50.42	O30.043	O41.1439	O99.282
I50.43	O30.091	O44.11	O99.283
I50.9	O30.092	O44.12	O99.311
I51.9	O30.093	O44.13	O99.312
I97.130	O30.101	O45.001	O99.313
I97.131	O30.102	O45.002	O99.321
O10.011	O30.103	O45.003	O99.322
O10.012	O30.111	O45.011	O99.323
O10.013	O30.112	O45.012	O99.341
O10.02	O30.113	O45.013	O99.342
O10.03	O30.121	O45.021	O99.343
O10.111	O30.122	O45.022	O99.351
O10.112	O30.123	O45.023	O99.352
O10.113	O30.191	O45.091	O99.353
O10.211	O30.192	O45.092	O99.411
O10.212	O30.193	O45.093	O99.412
O10.213	O30.201	O45.8X1	O99.413
O10.22	O30.202	O45.8X2	O99.42
O10.23	O30.203	O45.8X3	O99.43
O10.311	O30.211	O45.91	O99.841
O10.312	O30.212	O45.92	O99.842
O10.313	O30.213	O45.93	O99.843
O10.32	O30.221	O46.001	Q24.8
O10.33	O30.222	O46.002	Q25.9
O10.411	O30.223	O46.003	Q26.9
O10.412	O30.291	O46.011	Q27.9
O10.413	O30.292	O46.012	Q28.9
O10.42	O30.293	O46.013	Z20.4
O10.43	O41.1011	O46.021	Z20.820
O10.911	O41.1012	O46.022	Z20.828
O10.912	O41.1013	O46.023	
O10.913	O41.1014	O46.091	
O10.92	O41.1015	O46.092	
O10.93	O41.1019	O46.093	
O11.1	O41.1021	O46.8X1	
O11.2	O41.1022	O46.8X2	
O11.3	O41.1023	O46.8X3	

O13.1	O41.1024	O46.91	
O13.2	O41.1025	O46.92	
O13.3	O41.1029	O46.93	
O14.02	O41.1031	O47.02	

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

The following table combines obstetrical codes and instructions for **physicians** and **FQHC/RHC providers.** Information for **anesthesia providers** follows in a separate table.

Information for reimbursement of PMH procedure codes (S0280 *Medical home program, comprehensive care coordination and planning, initial plan* and S0281 *Medical home program, comprehensive care coordination and planning, maintenance of plan*) will be found in DMA's Clinical Coverage Policy 1E-6, *Pregnancy Medical Home* (on DMA's Website at http://www.ncdhhs.gov/dma/mp/). PMH providers shall bill according to the specifications in the table below. Indian Health Service PMH providers will bill RC 510, S0280, and S0281 for reimbursement for PMH services.

- Local Health Departments (LHDs) who provide only antepartum and postpartum care for pregnancy services shall bill CPT codes 59425, 59426, and 59430 for antepartum and postpartum care.
- LHDs who provide high-risk antepartum care shall bill appropriate Evaluation and Management (E/M) codes for individual antepartum services as specified in **Subsection 3.2.2**.
- LHDs who provide complete antepartum, labor and delivery, and postpartum care by employing or contracting with obstetric providers shall bill 59400, 59409, 59410, 59425, 59426, 59430, 59510, 59514, or 59515.

Routine Obstetrical Procedure Codes

HCPCS Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
T1015	Individual	Clinic visit/ encounter, all-inclusive	N/A	Rendering antepartum and postpartum care is a core service. ✦ Use the "A" suffix provider number.

Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician Services Guidelines**	**FQHC/RHC Guidelines**
59400	Global	Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	The provider billing for OB care shall have rendered at least 3 months of consecutive antepartum care to the beneficiary. ✦ The date the provider first saw the beneficiary for antepartum care shall be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim for the OB care shall be the date of delivery. ✦ This code cannot be billed in addition to other OB global codes.	N/A
59409	Individual	Vaginal delivery only (with or without episiotomy and/or forceps)	This code is limited to one unit within 225 days when billed by the same or different provider except as described in E below. ✦ If antepartum care and/or postpartum care are performed by the same provider, bill the appropriate global code. ✦ This code cannot be billed in addition to global OB codes. ✦ Birthing Centers use this code for reimbursement.	This code is limited to one unit within 225 days when billed by the same or different provider. ✦ Postpartum care services are not included in this code. ✦ ✦ Use the "C" suffix provider number.

Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician Services Guidelines**	**FQHC/RHC Guidelines**
59410	Package	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	This code is limited to one unit within 225 days when billed by the same or different provider. ✦ If antepartum care and/or postpartum care are performed by the same provider, bill the appropriate global code. ✦ This code cannot be billed in addition to global OB codes. ✦	N/A
59412	Individual	External cephalic version, with or without tocolysis	Use 59412 in addition to code(s) for delivery.	Use 59412 in addition to code(s) for delivery. ✦ Use the "C" suffix provider number.
59414	Individual	Delivery of placenta (separate procedure)	This code cannot be billed in conjunction with another delivery code. ✦ This code is limited to one unit within 225 days when billed by the same or different provider.	This code cannot be billed in conjunction with another delivery code. ✦ This code is limited to one unit within 225 days when billed by the same or different provider. ✦ Use the "C" suffix provider number.

Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician Services Guidelines**	**FQHC/RHC Guidelines**
59425	Package	Antepartum care only; 4–6 visits	The date the provider first saw the beneficiary for antepartum care shall be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim shall be the date of the last visit if the date of delivery is not known. ✦ This code cannot be billed in addition to other OB global codes. ✦ This code can be billed only once during the pregnancy with one unit by the same provider. (Refer to Subsection 5.2, letter b.) ✦ If delivery and postpartum care are also performed by the same provider, do not bill this code. Select a global code that includes all services provided.	N/A

Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician Services Guidelines**	**FQHC/RHC Guidelines**
59426	Package	Antepartum care only; 7 or more visits	The date the provider first saw the beneficiary for antepartum care shall be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim shall be the date of delivery. ✦ This code cannot be billed in addition to other OB global codes. ✦ This code can be billed only once during the pregnancy with one unit. ✦ If delivery and postpartum care are also performed by the same provider, do not bill this code. Select a global code that includes all services provided.	N/A
59430	Individual	Postpartum care only (separate procedure)	This code cannot be billed in addition to other OB global codes. ✦ This code includes 60 days postpartum. ✦ Do not use this code if delivery and antepartum care were performed by the same provider. Select a global code that includes all services provided.	N/A

Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician Services Guidelines**	**FQHC/RHC Guidelines**
59510	Global	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	The provider billing for OB care shall have rendered at least 3 consecutive months of antepartum care to the beneficiary. ✦ The date the provider first saw the beneficiary for antepartum care shall be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim for the OB care shall be the date of delivery. ✦ This code cannot be billed in addition to other OB global codes.	N/A
59514	Individual	Cesarean delivery only	This code is limited to one unit within 225 days when billed by the same or different provider except as described in E below. ✦ This code cannot be billed in addition to global OB codes. ✦ If antepartum care and/or postpartum care are performed by the same provider, bill the appropriate global code.	This code is limited to one unit within 225 days when billed by the same or different provider. ✦ Use the “C” suffix provider number.
59515	Package	Cesarean delivery only; including postpartum care	This code is limited to one unit within 225 days when billed by the same or different provider. ✦ If antepartum care is performed by the same provider, bill the appropriate global code.	N/A

Additional Obstetrical Services Procedure Codes				
CPT Code	**Type**	**Description**	**Physician Services Guidelines**	**FQHC/RHC Guidelines**
99360	Individual	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	Use this code with high-risk deliveries. ✦ Use this code when services are related only to the mother. ✦ Services shall be requested by a physician, and this request shall be documented in the medical record. ✦ Diagnosis substantiating the high risk shall be listed on the claim form. ✦ This code cannot be billed on the same date of service as, or in conjunction with, code 99464. ✦ This code cannot be billed on the same date of service as CPT codes 99354 through 99357. ✦ Refer to the CPT book for the descriptions and indications for physician standby services. ✦ This code is limited to 2 hours per day.	Use this code with high-risk deliveries. ✦ Use this code when services are related only to the mother. ✦ Services shall be requested by a physician, and this request shall be documented in the medical record. ✦ Diagnosis substantiating the high risk shall be listed on the claim form. ✦ This code cannot be billed on the same date of service as, or in conjunction with, code 99464. ✦ This code cannot be billed on the same date of service as CPT codes 99354 through 99357. ✦ Refer to the CPT book for the descriptions and indications for physician standby services. ✦ This code is limited to 2 hours per day. ✦ Use the “C” suffix provider number.

Additional Obstetrical Services Procedure Codes				
CPT Code	**Type**	**Description**	**Physician Services Guidelines**	**FQHC/RHC Guidelines**
99464	Individual	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	This code cannot be billed in conjunction with newborn resuscitation (99465). ✦ This code cannot be billed on the same date of service as code 99360 by the same provider.	This code cannot be billed in conjunction with newborn resuscitation (99465). ✦ This code cannot be billed on the same date of service as code 99360 by the same provider. ✦ Use the "C" suffix provider number.

Stand-by Services for Anesthesia Providers			
HCPCS Code	**Type**	**Description**	**Anesthesia Guidelines**
99360	Individual	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	Use this code with high-risk deliveries. ✦ Use this code when services are related only to the mother. ✦ Services shall be requested by a physician, and this request shall be documented in the medical record. ✦ Diagnosis substantiating the high risk shall be listed on the claim form. ✦ This code cannot be billed on the same date of service as, or in conjunction with, code 99464. ✦ This code cannot be billed on the same date of service as CPT codes 99354 through 99357. ✦ This code cannot be billed on the same date of service as any other anesthesia codes. ✦ Refer to the CPT book for the descriptions and indications for physician standby services. ✦ This code is limited to 1 hour (2 units) per day.

Postpartum Vaccinations	
CPT Code	**Description**
90396	Varicella-zoster immune globulin, human, for intramuscular use
90706	Rubella virus vaccine, live, for subcutaneous use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90716	Varicella virus vaccine, live, for subcutaneous use

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing for Multiple Births

The appropriate multiple gestation diagnosis code shall be on the claim for reimbursement.

Gestation	ICD-10-CM Code(s)		Additional Units to Be Billed
Twin	O30.001 O30.002 O30.003 O30.011 O30.012 O30.013 O30.031 O30.032	O30.033 O30.041 O30.042 O30.043 O30.091 O30.092 O30.093	**1**
Triplet	O30.101 O30.102 O30.103 O30.111 O30.112 O30.113	O30.121 O30.122 O30.123 O30.191 O30.192 O30.193	**2**
Quadruplet	O30.201 O30.202 O30.203 O30.211 O30.212 O30.213	O30.221 O30.222 O30.223 O30.291 O30.292 O30.293	**3**

In addition to the multiple gestation diagnosis code, the correct delivery codes are also required.

Type of delivery	CPT Code for First Birth No Modifier	Effective with DOS on and after 8/01/2009 CPT code and modifier for Consecutive Births	Effective with DOS 3/31/11 CPT code and modifier for Consecutive Births
All vaginal	59400 or 59409 or 59410	59409-**51** (one line for each additional birth)	59409-51,**59** (one line with one unit for each additional birth)
All cesarean	59510 or 59514 or 59515	59514-**51** (one line for each additional birth)	59514-51,**59** (one line with one unit for each additional birth)
Mixed—vaginal first	59400 or 59409 or 59410	59409-**51** (one line for each vaginal additional birth) or 59514-**51**,59 (one line for each additional cesarean birth)	59409-51,**59** (one line with one unit for each additional birth) or 59514-51,**59** (one line with one unit for each additional birth)

Note: For multiple births of more than four infants, submit the first claim electronically. It will deny with a request for operative notes. Submit the second claim as an adjustment with operative notes attached.

F. Place of Service

Inpatient hospital
Outpatient hospital
Office

G. Co-Payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://www.ncdhhs.gov/dma/plan/sp.pdf.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: http://www.ncdhhs.gov/dma/fee/

Attachment B: Billing for Obstetrical Services

The CPT procedure codes listed below may not be reimbursed separately if billed with CPT codes 59400, 59410, 59425, 59426, 59430 , 59510, or 59515 by the same billing provider.

CPT Code	Description
36415	Collection of venous blood by venipuncture
80048	Basic metabolic panel (Calcium, total)
80050	General health panel
80051	Electrolyte panel
80055	Obstetric panel
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; automated, without microscopy
82731	Fetal fibronectin, cervicovaginal secretions, semiquantitative
83020	Hemoglobin fractionation and quantitation; electrophoresis (e.g., A2, S, C, and/or F)
83021	Hemoglobin fractionation and quantitation; chromatography (e.g., A2, S, C, and/or F)
83026	Hemoglobin; by copper sulfate method, non-automated
83030	Hemoglobin; F (fetal), chemical
83036	Hemoglobin; glycosylated (A1C)
83045	Hemoglobin; methemoglobin, qualitative
83050	Hemoglobin; methemoglobin, quantitative
83051	Hemoglobin; plasma
83055	Hemoglobin; sulfhemoglobin, qualitative
83060	Hemoglobin; sulfhemoglobin, quantitative
83065	Hemoglobin; thermolabile
83068	Hemoglobin; unstable, screen
83069	Hemoglobin; urine
85046	Blood count; automated differential WBC count; reticulocytes, automated, including one or more cellular parameters (e.g., reticulocyte hemoglobin content [CHr], immature reticulocyte fraction [IRF], reticulocyte volume [MRV], RNA content), direct measurement

(continues)

CPT Code	Description (Evaluation and Management)
99201 through 99215	Office or other outpatient services
99217	Observation care discharge day management
99218 through 99220	Initial observation care
99221 through 99239	Hospital inpatient services
99241 through 99245	Office or other outpatient consultations
99251 through 99255	Inpatient consultation

Billing Individual Evaluation and Management Codes for 1-3 Visits

When an obstetrical patient is seen by the obstetric provider between one (1) and three (3) visits, the visits would be coded as an E/M service, according to the services that were provided. If the patient is new to the physician, codes 99201-99205 shall be reported for the new patient initial visit. E/M codes 99211-99215 for an established patient shall be reported for the next two visits.